Department of Regulation & Licensing

State of Wisconsin
(608) 266-2852
TTY# (608) 267-2416
TRS# 1-800-947-3529] - hearing or speech impaired only

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OFFICE OF EXAMINATIONS

PROFESSIONAL VERIFICATION OF REQUEST FOR MODIFICATION

Information requested is required for processing.

_____, a candidate for examination by the Wisconsin Department of Regulation and Licensing, has made a request for modification of examination based on a disability of the applicant.

The purpose of this form is to request your professional opinion concerning the disability and the modification requested. Please answer the questions below and sign the certification. The opinion you provide will be used in evaluating the request.

The information obtained on this form will be treated as a medical record except that exam proctors and exam providers may be informed regarding necessary modifications to exam procedures, and first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

(Professional verification is NOT to be completed by the applicant.)

Please respond to the following questions regarding the above mentioned individual. Use additional sheets where necessary. Previously prepared diagnostic reports may be submitted if all questions below are answered by the report, and the report is less than 5 years old.

1. What is the specific diagnosis of the disability?

2. On what date did you make this diagnosis? _____

3. When did you last evaluate or treat the candidate?_____

4. What are the specific findings which support the diagnosis (relevant history, tests administered, test results and interpretation of those test results)? Attach extra sheets as needed.

5. What are the individual's functional limitations due to the stated disabilities?

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6. What are your specific recommendations for test modifications? Please include a detailed explanation of why the modifications are needed by this candidate.

7. Please describe your qualifications/credentials and professional relationship with this candidate which qualifies you to provide these recommendations for testing.

I certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the diagnosis and assessment of modification request described above is my professional judgment. I understand that the department may contact me (with the candidate's permission) to obtain further information if necessary, and that the department may obtain an independent assessment by a second professional.

Signature of Professional	Name of Institution or Practice
Typed or Printed Name of Professional	Street Address
Title	City, State, ZIP Code
Telephone Number (include area code)	Date

CANDIDATE: I give the Department of Regulation and Licensing permission to contact the above professional and discuss the findings of this report.

Signature of Candidate	Date

** Questions about this form or the department policy for accommodation of disabilities may be addressed to the Office of Examinations, (608) 266-2852, or TTY at (608) 267-2416.